Medication Contract

I, _____, have agreed to use the following medications as part of my treatment for chronic pain. I understand that these medications may not eliminate my pain but may reduce it and improve what I am able to do each day.

MEDICATION	DOSE	DIRECTIONS	QUANTITY PER MONTH

I understand the following guidelines for continuing pain treatment under the care of _____

1. I understand that I have the following responsibilities:
    - I will take medications at the dose and frequency prescribed.
    - I will not increase or change how I take my medications without the approval of this health care provider.
    - I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends.
    - I will obtain all refills for these medications only at _____ pharmacy (phone number: _____), with full consent for my provider and pharmacist to exchange information in writing or verbally.
    - I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medications I am taking.
    - I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In event of an emergency, I will provide this same information to emergency department providers.
    - I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
    - I will keep medications only for my own use and will not share them others. I will keep all medications away from children.
    - I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider.

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- I will actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities.

2. I will not use illegal or street drugs or another person's prescription. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include:
   - 12-step program and securing a sponsor
   - Individual counseling
   - Inpatient or outpatient treatment
   - Other:_____

If in treatment, I will request that a copy of the program's initial evaluation and treatment recommendations be sent to this provider and will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.

3. I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

4. I will keep all my scheduled appointments. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled.

5. I understand that this provider may stop prescribing the medications listed if:
   - I do not show any improvement in pain or my activity has not improved.
   - I develop rapid tolerance or loss of improvement from the treatment.
   - I develop significant side effects from the medication.
   - My behavior is inconsistent with the responsibilities outlined above, ***which may also result in being prevented from receiving further care from this clinic***.

Signed: _____ Date: _____

Provider: _____ Date: _____